

**WEST VIRGINIA DIVISION OF MOTOR VEHICLES
INTERNATIONAL REGISTRATION PLAN
STATE CAPITOL BUILDING 3 ROOM 60
CHARLESTON, WEST VIRGINIA 25317**

This application is to be used in applying for duplicate apportioned cab card, license plate or decals. A new cab card, license plate or decal will be issued if the Commissioner is satisfied the original is lost, destroyed or stolen, and upon certification to that effect.

PLEASE TYPE OR PRINT

Account	Fleet No.	Supplement No. Vehicle Added	Group No.
Name of Registrant			
Business Address (physical location of fleet)			
City	State	Zip Code	
Mailing Address (do not write "same")			
City	State	Zip Code	
Equipment Number	DMV USE ONLY		
Class _____ Apportioned License Number _____			

If duplicate cab card is desired, check here _____ Fee \$5.00
 If duplicate yearly decal is desired, check here _____ Fee \$5.00
 If duplicate plate is desired, check here _____ Fee \$5.00
 If duplicate plate is desired, check here _____ Fee \$5.00

A Statement of Insurance must be submitted with each application for a duplicate plate issued to a power unit. There is a 50¢ Insurance Enforcement Fee. Give reason for replacement. _____

COMPLETE INSURANCE STATEMENT ON REVERSE SIDE

Have any of your vehicle registrations been revoked or suspended in the past five years? Yes _____ No _____

If yes, reason _____

I hereby certify, under penalty of false swearing, that the statements made herein are true and correct to the best of my knowledge and belief.

 Authorized Signature of Applicant

REGISTRANT'S STATEMENT OF INSURANCE

DATE _____ LICENSE NUMBER _____

REGISTRANT NAME _____

REGISTRANT ADDRESS _____

 YEAR MAKE VEHICLE IDENTIFICATION NUMBER

I HEREBY STATE, UNDER PENALTY OF FALSE SWEARING AND PENALTIES OUT-LINED IN CHAPTERS 17A AND 17D, THAT THERE IS IN EFFECT A MOTOR VEHICLE LIABILITY POLICY UPON THE DESCRIBED VEHICLE IN ACCORDANCE WITH THE PROVISIONS OF THE WEST VIRGINIA MOTOR VEHICLE CODE.

SIGNATURE OF REGISTRANT _____

EFFECTIVE DATE OF INSURANCE POLICY _____ TO _____

NAME OF INSURANCE COMPANY _____

NAME OF INSURANCE AGENT _____

NAME OF POLICY NUMBER _____